DD-097-1 -PF (11-06)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

PRE-SERVICE PROVIDER ORIENTATION

INSTRUCTIONS: This form is to be completed by the provider and the individual and/or responsible party receiving services prior to the initiation of services. A copy MUST be retained by the provider and a copy sent to the District Office. The provider must also ensure that a General Consent and Authorization form is completed and retained by the provider.

PROVIDER INFORMATION

PROVIDER'S NAME *(Last, First, M.I.)*	EMPLOYER TAX NO.	AHCCCS ID NO.

IS THERE ANY SPECIAL TRAINING REQUIRED?

☐ Yes ☐ No Describe:

Med Training Needed ☐ Yes ☐ No Seizure Management Training Needed ☐ Yes ☐ No

CRITICAL INFORMATION

INDIVIDUAL'S NAME *(Last, First, M.I.)*	ASSISTS NO.	BIRTHDATE

INDIVIDUAL'S ADDRESS *(No., Street, City, State, ZIP)*

GUARDIAN/RESPONSIBLE PARTY'S NAME *(Last, First, M.I.)*	RELATIONSHIP	PHONE NO.

ADDRESS *(No., Street, City, State, ZIP)*

EMERGENCY CONTACT'S NAME *(If other than responsible party)*	RELATIONSHIP	PHONE NO.

SUPPORT COORDINATOR'S NAME	OFFICE LOCATION	PHONE NO.

NAME OF ALTCS/DDD HEALTH PLAN	AHCCCS ID NO.	PHONE NO.

PRIMARY CARE PHYSICIAN'S NAME	PHONE NO.

ADDRESS *(No., Street, City, State, ZIP)*

URGENT CARE FACILITY'S NAME	PHONE NO.

ADDRESS *(No., Street, City, State, ZIP)*

OTHER HEALTH INSURANCE INFORMATION

DAY PROGRAM *(If applicable)*

NAME OF DAY PROGRAM	PROGRAM TYPE	DAYS AND HOURS OF ATTENDANCE	TRANSPORTATION METHOD

DAY PROGRAM ADDRESS *(No., Street, City, State, ZIP)*	PHONE NO.

HEALTH – MEDICAL

CURRENT MEDICATIONS AND SIGNIFICANT HISTORICAL MEDICATION ISSUES:

MED LOG REQUIRED	SPECIAL MEDICATION INSTRUCTIONS
☐ Yes ☐ No	

ALLERGIES TO:

Food ☐ Yes ☐ No Specify Medication ☐ Yes ☐ No Specify

Bee Stings ☐ Yes ☐ No Specify Other ☐ Yes ☐ No Specify

RECOMMENDED RESPONSE TO ALLERGIC REACTION

SEIZURES: ☐ Yes ☐ No

DESCRIBE	FREQUENCY	APPROXIMATE DURATION

RECOMMENDED RESPONSE TO SEIZURE ACTIVITY

ASSISTIVE DEVICES

VISION	HEARING	DENTAL APPLIANCES

PROTECTIVE DEVICES:

INSTRUCTIONS FOR USE	PURPOSE

OTHER INDIVIDUALIZED HEALTH CARE ROUTINES

Distribution: White – Provider; White – District Office; Canary – Parent/Guardian; Pink – Support Coordinator

See next page for EOE/ADA disclosures

Equal Opportunity Employer/Program

Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, and disability. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at (602) 542-6825; TTY/TDD Services: 7-1-1.